114.3 CMR Division of Health Care Finance and Policy

114.3 CMR 15.00: VISION CARE SERVICES AND OPHTHALMIC MATERIALS

Section

15.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 15.00 shall govern the determination of rates of payment to be used by all governmental units and purchasers under M.G.L. c. 152, § 1 *et seq* (the Workmen's Compensation Act) for vision care services and ophthalmic materials provided to publicly-aided and industrial accident patients. 114.3 CMR 15.00 shall be effective on July 1, 2005.

(2) Disclaimer of Authorization of Services. 114.3 CMR 15 is not authorization for or approval of the procedures for which rates are determined pursuant to 114.3 CMR 15.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services extended to publicly-aided clients.

(3) Informational Bulletins. The Division may issue administrative information bulletins to clarify its policy on and understanding of substantive provisions of 114.3 CMR 15.00.

(4) Coding Updates and Corrections. The Division may publish procedure code updates and corrections in the form of an Informational Bulletin. Updates may reference coding systems including but not limited to the American Medical Association's *Current Procedural Terminology* (CPT). The publication of such updates and corrections will list:

(a) codes for which only the code numbers change, with the corresponding cross references between existing and new codes;
(b) deleted codes for which there are no corresponding new codes; and codes for entirely new services that require pricing. The Division will list these codes and apply individual consideration (IC) reimbursement for these codes until appropriate rates can be developed.

(5) Coverage. 114.3 CMR 15.00 and the rates of payment contained herein shall apply to the following situations:

(a) Ophthalmologists. Where the ophthalmologist dispenses ophthalmic materials (frames and lenses for eyeglasses, etc.) the rates of payment contained

herein for dispensing and ophthalmic materials shall apply. Where the ophthalmologist performs a comprehensive eye examination as defined herein, the rates of payment contained herein for a comprehensive eye examination shall apply. Medical examinations of the eye and dispensing of contact lenses by ophthalmologists, however, are not the subject matter of 114.3 CMR 15.00.

(b) Optometrists. 114.3 CMR 15.00 and the rates of payment contained herein shall apply to vision care services and ophthalmic materials provided by optometrists, except as otherwise provided herein.

(c) Opticians. 114.3 CMR 15.00 and the rates of payment contained herein shall apply to the dispensing of ophthalmic materials by opticians, except as otherwise provided herein.

With respect to the above situations, the rates of payment under 114.3 CMR 15.00 are full compensation for vision services rendered to publicly-aided and industrial accident patients as well as for any related administrative or supervisory duties in connection with the provision of vision care services without regard to where the services are rendered.

(6) Exception from Coverage: Bulk Purchase Contract. In cases where the conditions of participation for eligible providers of vision care services call for the provider to order material from designated suppliers under a bulk purchase contract between the suppliers and a governmental unit, the eligible provider must bill the governmental unit under 114.3 CMR 15.00 for the relevant dispensing fee only.

(7) Authority. 114.3 CMR 15.00 is adopted pursuant to M.G.L.c.118G.

15.02: General Definitions

(1) Meaning of Terms. The terms used in 114.3 CMR 15.00 shall have the meanings ascribed in 114.3 CMR 15.02 and in the CPT Coding Handbook. The descriptions and five-digit procedure codes included in the Regulation 114.3 CMR 15.00 are obtained from the Physicians' *Current Procedural Terminology* (CPT), copyright 2004 by the American Medical Association, or the 2005 Healthcare Common Procedure Coding System Level II (HCPCS) unless otherwise specified. Both sources provide a listing of descriptive terms and alpha-numeric identifying codes and modifiers for reporting medical services and procedures performed by health care providers.

Actual Cost. For frames and cases, the invoice price charged the dispensing eligible provider by the optical wholesale firm or other supplier which manufactured or distributed the specific frame or case dispensed.

Confirmatory (Additional Opinion) Consultation. When the consulting physician or Ophthalmologist or Optometrist is aware of the confirmatory nature of the opinion that is sought (e.g., when a patient requests a second/third opinion on the necessity or appropriateness of a recommended medical treatment or surgical procedure).

Consultation. A type of service provided by a physician or Ophthalmologist or Optometrist whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or Ophthalmologist or Optometrist or other appropriate source.
A physician consultant may initiate diagnostic and/or therapeutic services.
The request for a consultation from the attending physician or Ophthalmologist or Optometrist or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.
Any specifically identifiable procedure (i.e. identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.
If a consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used.

Division. Division of Health Care Finance and Policy.

DMA. The Division of Medical Assistance

Eligible Provider of Vision Care Services and Ophthalmic Materials. Ophthalmologists, optometrists and dispensing opticians who are registered by an appropriate board of registration in accordance with the provision of M.G.L.c.112 and are not under contractual arrangement with a hospital or affiliated teaching institution for professional services and who also meet such conditions of participation as may be required by a governmental unit purchasing vision care services and ophthalmic materials or by purchasers under M.G.L.c.152.

Established Patient. A patient who has received professional services from the physician or Ophthamologist or Optometrists within the past three years.

Evaluation and Management (E/M) Services. E/M services represent a way of classifying the work of physicians and Ophthalmologists and Optometrists. In particular, they involve far more clinical detail than the old visit codes. The E/M section is divided into broad categories such as office visits, hospital visits and consultations. Most of the

categories are further divided into two or more subcategories of E/M services. For a full discussion of these services, refer to the 1999 CPT handbook.

Individual Consideration. The process to establish a fee for a medical or Ophthalmologists or Optometrists service is determined by a purchasing governmental unit or purchaser under M.G.L.c.152, based among other things, on the nature, extent and need for such service, and the degree of skill and time required for its provision.

Levels of E/M Services. Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians or Optometrists. Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

For a full discussion of the levels of E/M services, please refer to the 1999 CPT handbook.

Governmental Unit. The Commonwealth, any department, agency, board or commission of the Commonwealth and any political subdivision of the Commonwealth

Publicly-Aided Individual. A person for whose medical and other services a governmental unit is in whole or in part liable under a statutory program.

New Patient. A patient who has not received any professional services from the physician or Ophthalmologist or Optometrist within the past three years.

Level I Optometrist. An optometrist who is not qualified to apply topical agents.

Level II Optometrist. An optometrist who has completed the required course of study and passed the examination necessary to obtain certification to apply topical agents.

Low Vision. Any pathological, traumatic or congenital condition of the eye or brain which results in reduced visual acuity or reduction of visual field, and which is not amenable to medical, surgical or ordinary optical correction.

Low Vision Aids. Includes, but is not limited to, microscopic and telescopic lenses to correct low vision.

Low Vision Evaluation. A series of evaluative vision tests to measure the degree of low vision and the corrective lenses or aids required.

Modifiers. Listed services may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two digit number or letters placed after the usual procedure number from which it is separated by a hyphen.

Ocular Prosthetic Services. The dispensing and adjustment of false eyes

Vision Care Services and Ophthalmic Materials. Professional care of the eye for the purpose of diagnosing and correcting refractive errors and includes the measurement, specification, formulation, construction and dispensing of eyeglasses and related eye care appliances.

15.03: General Rate Provisions

(1) Rate Determination. Rates of payment for authorized vision care services and ophthalmic materials to which 114.3 CMR 15.00 applies shall be the lower of:

(a) the eligible provider's usual fee to patients other than publicly-aided or industrial accident patients; or

(b) the schedule of allowable fees set forth in 114.3 CMR 15.04

(2) Individual Consideration. Rates of payment to an eligible provider of vision care services for procedures not listed herein or authorized procedures performed in exceptional circumstances shall be determined on an Individual Consideration (I.C.) basis by the governmental unit or purchaser under M.G.L.c.152, upon receipt of a bill which describes the services rendered. Determination of appropriate payment for authorized I.C. procedures shall be in accordance with the following criteria:

(a) time required to perform the procedure;

(b) degree of skill required for the procedure rendered;

(c) severity and complexity of the patient's disorder or disability;

(d) cost of goods supplied in rendering the service; catalogues of major suppliers should be used as a reference;

(e) policies, procedures and practices of other third party purchasers of care, governmental and private.

15.04: Allowable Fees for Vision Care Services

Modifiers

-52 Reduced Services. Under certain circumstances a service or procedure is partially reduced or eliminated at the provider's election. Under these circumstances, the service provided can be identified by its usual procedure number with the addition of the modifier '-52' signifying that the service is reduced, and 86% of the unmodified rate would be paid. For example, there are eye examinations provided by a Level II optometrist when eyedrops would be used. Because Level I optometrists are not certified to distribute eyedrops, the addition of the –52 modifier to the appropriate procedure code allows 86% of the fee contained in 114.3 CMR 15.03 as the allowable fee to be paid to the Level I optometrist.

Visual Analysis

(All rates are for Level I and II optometrists unless otherwise specified.)

PROCEDURE CODE	RATE	DESCRIPTION
76512	$93.33	Ophthalmic ultrasound, diagnostic; B-scan with or without superimposed non-A-scan quantitative (level II optometrist)
76513	$93.33	Ophthalmic ultrasound, anterior segment ultrasound, immersion (water bath)(level b-scan or high resolution biomicroscopy II optometrist)
76514	$8.22	Ophthalmic ultrasound, diagnostic, corneal pachymetry, unilateral or bilateral (determination of corneal thickness)
92002	$48.72	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	$63.06	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	$40.80	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	$46.37	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92015	$11.59	Determination of refractive state
92020	$18.98	Gonioscopy (separate procedure)
92065	$25.91	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92081	$20.02	Visual field examination, unilateral or bilateral, with interpretation and report; limited

		examination (e.g. tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
92082	$55.52	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g. at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	$81.57	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g. Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 , or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100	$28.41	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g. diurnal curve or medical treatment of acute elevation of intraocular pressure)
92120	$27.44	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	$31.97	Tonography with water provocation
92135	$49.09	Scanning computerized ophthalmic diagnostic imaging (eg, scanning laser) with interpretation and report, unilateral
92140	$19.55	Provocative tests for glaucoma, with interpretation and report, without tonography
92225	$46.21	Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial
92226	$41.88	Ophthalmoscopy, extended, with retinal drawing (e.g. for retinal detachment, melanoma), with interpretation and report; subsequent
92230	$71.32	Fluorescein angioscopy with interpretation and report
92250	$31.06	Fundus photography with interpretation and report
92260	$25.29	Ophthalmodynamometry
92275	$84.11	Electroretinography with interpretation and report
92285	$37.36	External ocular photography with interpretation and report for documentation of medical progress (eg, closeup photography, slit lamp photography, goniophotography, stereo-photography)

92310	I.C.	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia (for prescription and fitting of one eye, add modifier '–52')
92326	$47.41	Replacement of contact lens
92340	$26.13	Fitting of spectacles, except for aphakia; monofocal
92340 RP	$8.47	Fitting of spectacles, except for aphakia; monofocal (replacement and repair) (per lens)
92341	$32.25	Fitting of spectacles, except for aphakia; bi-focal
92341 RP	$12.67	Fitting of spectacles, except for aphakia; bi-focal (replacement and repair) (per lens)
92342	$32.25	Fitting of spectacles, except for aphakia; multi-focal other than bi-focal
92342 RP	$12.67	Fitting of spectacles, except for aphakia; multi-focal other than bi-focal (replacement and repair) (per lens)
92370	$10.37	Repair and refitting spectacles, except for aphakia
92392	I.C.	Supply of low vision aids (a low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction. Includes reading additions up to 4D.)
92395	I.C.	Supply of permanent prosthesis for aphakia; spectacles
92396	I.C.	Supply of permanent prosthesis for aphakia; contact lenses
92499	I.C.	Unlisted ophthalmological service or procedure
92541	$40.61	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	$35.66	Positional nystagmus test, minimum of 4 positions, with recording
92544	$27.61	Optokinetic nystagmus test, bi-directional, foveal or peripheral stimulation, with recording
99173	$21.98	Screening test of visual acuity, quantitative, bilateral
99201	$25.88	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	$46.40	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	$69.18	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed

		examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	$98.08	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	$124.27	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	$15.83	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	$27.67	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	$38.24	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214	$59.86	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	$87.14	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99241	$34.08	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	$52.64	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	$67.92	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	$94.72	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting

		problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	$128.09	Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99251	$35.49	Initial inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
99301	$46.42	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit.
99302	$58.91	Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit.
99303	$75.14	Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The creation of a medical plan of care is required.

		Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit.
99311	$25.58	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
99312	$38.06	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99313	$52.40	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.
99323	$62.78	Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of a high complexity.
99333	$43.80	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; and medical decision making that is of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is unstable or has developed a significant complication or a significant new problem.

T2002	$3.85	Non-emergency transportation; per diem

FRAMES

V2020	$51.83	Frames, purchases
V2025	I.C.	Deluxe frame

SINGLE VISION, GLASS OR PLASTIC

V2100	$28.65	Sphere, single vision, plano to plus or minus 4.00, per lens
V2101	$30.21	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens
V2102	$42.48	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens
V2103	$24.89	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2104	$27.55	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2105	$30.01	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2106	$35.76	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2107	$31.65	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens
V2108	$32.77	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2109	$36.29	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2110	$36.49	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens
V2111	$37.32	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2112	$40.73	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens
V2113	$47.08	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2114	$49.73	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens
V2115	$54.12	Lenticular (myodisc), per lens, single vision
V2118	$71.53	Aniseikonic lens, single vision
V2121	$61.85	Lenticular lens, per lens, single
V2199	I.C.	Not otherwise classified, single vision lens.

BIFOCAL, GLASS OR PLASTIC

V2200	$40.46	Sphere, bifocal, plano to plus or minus 4.00d, per lens

V2201	$43.26	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2202	$49.31	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d,per lens
V2203	$40.18	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2204	$42.41	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2205	$45.11	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2206	$47.05	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2207	$45.61	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2208	$46.49	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2209	$52.66	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2210	$52.71	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2211	$59.11	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2212	$64.29	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2213	$61.96	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2214	$61.26	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
V2215	$62.19	Lenticular (myodisc), per lens, bifocal
V2218	$98.66	Aniseikonic, per lens, bifocal
V2219	$32.58	Bifocal seg width over 28mm
V2220	$26.41	Bifocal add over 3.25d
V2221	$77.03	Lenticular lens, per lens, bifocal
V2299	I.C.	Specialty bifocal (by report).

TRIFOCAL, GLASS OR PLASTIC

V2300	$52.91	Sphere, trifocal, plano to plus or minus 4.00d, per lens
V2301	$71.93	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens
V2302	$79.98	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens
V2303	$53.34	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2304	$54.74	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens
V2305	$68.21	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens

V2306	$66.01	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2307	$71.88	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2308	$74.04	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2309	$84.54	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2310	$71.58	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder per lens
V2311	$82.20	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2312	$87.40	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2313	$95.25	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2314	$78.64	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
V2315	$116.39	Lenticular, (myodisc), per lens, trifocal
V2318	$143.10	Aniseikonic lens, trifocal
V2319	$38.93	Trifocal seg width over 28 mm
V2320	$38.33	Trifocal add over 3.25d
V2321	$113.65	Lenticular lens, per lens, trifocal
V2399	I.C.	Specialty trifocal (by report).

VARIABLE ASPHERICITY

V2410	$65.59	Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	$80.62	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499	I.C.	Variable sphericity lens, other type.

CONTACT LENSES

If procedure code 92391 or 92396 is reported, recode with specific lens type listed below (per lens)

V2500	$62.36	Contact lens, PMMA, spherical, per lens
V2501	$120.78	Contact lens, PMMA, toric or prism ballast, per lens
V2502	$146.49	Contact lens PMMA, bifocal, per lens
V2503	$137.03	Contact lens PMMA, color vision deficiency, per lens
V2510	$92.67	Contact lens, gas permeable, spherical, per lens
V2511	$155.53	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	$162.97	Contact lens, gas permeable, bifocal, per lens
V2513	$132.05	Contact lens, gas permeable, extended wear, per lens
V2520	$89.82	Contact lens hydrophilic, spherical, per lens

V2521		$137.98	Contact lens hydrophilic, toric, or prism ballast, per lens
V2522		$169.39	Contact lens hydrophilic, bifocal, per lens
V2523		$142.36	Contact lens hydrophilic, extended wear, per lens
V2530		$217.56	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2531	I.C.		Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2599		I.C	Contact lens, other type.

LOW VISION AIDS

If procedure code 92392 is reported, recode with specific systems listed below

V2600	I.C.	Hand held low vision aids and other non-spectacle mounted aids
V2610	I.C.	Single lens spectacle mounted low vision aids
V2615	I.C.	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system

PROSTHETIC EYE

V2623	I.C.	Prosthetic eye, plastic, custom
V2624	I.C.	Polishing/resurfacing of ocular prosthesis
V2625	I.C.	Enlargement of ocular prosthesis
V2626	I.C.	Reduction of ocular prosthesis
V2627	I.C.	Scleral cover shell
V2628	I.C.	Fabrication and fitting of ocular conformer
V2629	I.C.	Prosthetic eye, other type

INTRAOCULAR LENSES

V2630	I.C.	Anterior chamber intraocular lens
V2631	I.C.	Iris supported intraocular lens
V2632	I.C.	Posterior chamber intraocular lens

MISCELLANEOUS

V2700	$33.59	Balance lens, per lens
V2710	$46.90	Slab off prism, glass or plastic. per lens
V2715	$8.49	Prism, per lens
V2718	$27.01	Press-on lens, fresnell prism, per lens
V2730	$15.81	Special base curve, glass or plastic, per lens
V2744	$12.00	Tint, photochromatic, per lens

V2745	$7.46	Addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens
V2750	$13.96	Anti-reflective coating, per lens
V2755	$16.19	U-V lens, per lens
V2760	$12.34	Scratch resistant coating, per lens
V2770	$19.04	Occluder lens, per lens
V2780	$10.04	Oversize lens, per lens
V2781	I.C.	Progressive lens, per lens
V2785	I.C.	Processing, preserving and transporting corneal tissue
V2799	I.C.	Vision service, miscellaneous

15.05: Severability

The provisions of 114.3 CMR 15.00 are severable, and if any provision of 114.3 CMR 15.00 or application of such provision to any eligible provider of vision care services and ophthalmic materials or any circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.3 CMR 15.00 or application of such provisions to eligible providers of vision care services and ophthalmic materials or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 15.00; M.G.L.c.118G